Letters

The GMC: expediency before principle

BMA chairman responds

EDITOR—The *BMJ*'s rigorously exercised editorial independence is well shown, but lest Editor's choice and Smith's editorial on the General Medical Council are mistaken for BMA policy, I emphasise that these were not the BMA's views in the wake of the fifth report of the Shipman inquiry.[1 2]

Richard Smith, a long-term critic of the GMC, says that Dame Janet Smith finds deficiencies in the GMC's new fitness to practise procedures introduced in November 2004. Would it not be sensible to allow the new system a chance to prove itself before condemning its existence? In chapter 27 of her latest report Dame Janet says that broadly speaking the changes are an improvement, stating: "I do not know how well they will operate in the interests of patient protection." She believes it would be sensible to allow the new procedures "to develop and settle down before their adequacy and fitness for purpose is judged." The editorial does not reflect this.

The inquiry set out to ensure that another Shipman would be detected very quickly. The BMA supports the suggested reform of the coronial system, death certification procedures, and drug monitoring that will help this.

The inquiry also set out to enhance the prospect of detecting aberrant behaviour or substandard performance in doctors. The new systems of appraisals and revalidation do that, and I hope that the current delay in their introduction is as short as possible. Developing revalidation has been difficult for the profession, but doctors have worked determinedly with the GMC to produce a system that would work. They deserve credit for that.

The third aim of the inquiry was to allow scope and opportunity for the continued improvement of "the good quality care provided by the large majority of doctors." Response to the inquiry has to be proportionate, and this last aim must not suffer in the rush to secure the first two. Doctors in the United Kingdom already feel more regulated, micro-managed, and subject to bureaucracy than colleagues in other countries.

Smith says that wherever there has been a trade off between protecting the public and being fair to doctors the GMC has taken the side of doctors. Is this borne out by the facts? Most doctors still work in fear of a letter from the GMC, and recent events suggest the GMC has been bending over backwards to ensure that it is not seen as protecting doctors.

Dame Janet recognises that, as well as protecting patients, the GMC has a duty towards doctors and "must be fair in all its dealings with them," but she believes that the balance has been wrong. I do not regard being fair to doctors as a crime. I would expect any regulator to ensure that it is fair to all parties.

The BMA is in favour of professionally led regulation. It backed the need for change in the GMC, now let us allow time for the benefits of those changes to be shown as being fair to doctors and protecting patients.

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Competing interests: None declared.

1 Abbasi K. Editor's choice. An important debate on the GMC. *BMJ* 2005;330:0. (1 January.)
2 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)

GMC reforms may damage the NHS

EDITOR—In his editorial Smith doubts that the GMC can reform.[1] This paves the way for more political overreaction to Dame Janet Smith's reports of the Shipman inquiry.

The desire to achieve a culture of strict regulation is resulting in the appointment to the GMC of lay members selected for their anti-doctor sentiment by an anti-doctor government administration. Medicine may be justifiably considered a special case, but the proposals for accountability and disciplinary procedures go far beyond those of the judiciary and civil service.

A disproportionate level of punitive action is proposed, with procedures becoming like criminal investigations for suspected departures from standards of professional conduct. Underlying this is often a test of attitude rather than competence, with draconian suspensions of caring clinicians for being "off message" with a Department of Health tainted with government spin.

The witches of Salem approach to the retention of tissue at Alder Hey, for example, was unfair to the medical staff and damaging to a high standard children's hospital. The end result was needless prolonged anxiety to families and unresolved legal action. I wonder whether Dame Janet regards this as a desirable outcome.

An unhealthy climate of fear has developed across a profession that is in danger of becoming deprofessionalised—perhaps the political objective but surely not in the public interest. It is undoubtedly inhibiting clinical decision making in primary care, hospital emergency departments, and elsewhere, with defensive clinical practices leading to large hidden costs and a paralysing bureaucracy.

Legal, risk management, and clinical governance departments are the fastest growing areas of the NHS, diverting substantial funds from direct patient care.

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Competing interests: None declared.

1 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)

Self regulation is a contradiction in terms

EDITOR—Isn't it now time that we as doctors acknowledged that professional self regulation is a contradiction in terms?[1] Do we trust any other professionals to self regulate—for example, lawyers, politicians, the police? I think not, so why should any layperson trust us in this regard?

If we had the humility and courage to say this publicly we would gain more in public respect than we would lose in self esteem.

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1 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)

A former BMA chairman responds

EDITOR—Inexplicable omissions in Smith's intemperate editorial on the GMC prompt me to break an unhappy silence.[1]

Late in 1994 the British Medical Association organised a core values conference for the whole profession (BMA, royal colleges,

deans, GMC). It addressed the challenges facing the profession as outlined by an eminent lay member of the GMC, which, led by its then president, Lord Kilpatrick, had already formulated performance review procedures and called for action by us all.

During the following turbulent years—and intensively during 1997 and early 1998—discussions in each part of the profession culminated in a historic commitment, "self-regulation and clinical governance at local and national levels," co-signed by the chairmen of all the leading medical organisations, which was sent to the Secretary of State for Health, Frank Dobson, and others on 2 July 1998. In a covering letter Sir Norman Browse, chairman of the Joint Consultants Committee, on behalf of the whole profession, expressed the belief that the document complemented the government's contemporaneous clinical governance proposals and that they would "together solve problems *at an early stage and at local level*." The italics are mine to emphasise that the profession's united commitment was to deliver accountability through acting proactively at the earliest possible stage in identifying any problem with a colleague through its various mechanisms. The culture change to which the whole profession thereby committed itself was early prevention at source, rather than leaving problems to the GMC to resolve when it was too late.

What happened to this initiative? I believe that, had it been vigorously pursued, much if not all the trauma of the past six years could have been avoided. What I do know is that within days of its release a number of the co-signatories, myself included, had demitted office and Sir Donald Irvine, as president of the GMC, had produced his revalidation proposals. It is difficult to resist concluding that shifting the focus to these proposals (now seen to be flawed) distracted the profession as a whole from the more promising combined operation on which it had embarked.

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1 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)

Are doctors failing or is the system?

EDITOR—The GMC suggests that its job is guiding doctors,[1] but when I wrote for guidance on reasonable practice I was told that it could not offer guidance on specific areas as consensus was too difficult to obtain. I instead had to contact a medical defence organisation for advice.

I was concerned that the GMC had lost its way. A lawyer friend described the GMC as an archaic court whose primary interest is to stop doctors from embarrassing each other. Though harsh, this explains the council's near fanatical zeal in stopping doctors from falling in love with their patients and the slowness of its response for doctors who deliberately kill them.

The answer is to scrap the concept of serious professional misconduct. The GMC should be interested solely in whether the doctor committed a crime and how that should affect the doctor's practice. This work would include ensuring that doctors who have practised abroad have not committed criminal offences there.

A separate agency would help doctors with problems. Currently some doctors refuse to participate as they find the system unhelpful, which it is for many. All doctors should have access to confidential formative assessment so they are informed about their performance; appraisee led appraisal with mentor based support; and assessment process to diagnose performance difficulties. Failing doctors should have a full range of support measures.

Looking after healthcare staff is and will be expensive, but is it not time that one of the main resources in the health service was properly managed? Half of doctors will always be below average, so it is up to the employer to ensure that they have systems in place to attract the best doctors they can. Problems with competence will then be solved by market forces.

The basic principle should be that no doctor loses his or her right to practise without having committed a crime.

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1 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)

Doctors and patients have shared interests

EDITOR—Smith and Dyer wrote concise and lucid expositions of the latest report on the GMC.[1 2] Although it is crucial that the public is happy with the way that the profession regulates itself, I am troubled by the assumption in the conclusions of the report that protecting the interests of doctors and protecting the interests of patients are mutually exclusive.

Many a management guru has said that if you want to provide excellent customer care, you should treat your staff in the same way as you would like them to treat your most valued customer. Taken to its logical conclusion, patients can presumably look forward to being treated as incompetent until proved otherwise, at best, and as potential psychopaths at worst.

As someone who regularly supports and counsels doctors, I weep for the vast majority who work with competence and enormous commitment, often to the detriment of their health and personal lives, and yet are subject to blanket condemnations and more monitoring every time a rogue doctor comes to light. But if it is true that people treat customers in the same way that they are treated themselves, it is patients, paradoxically, who will ultimately pay the price for this relentless and hopeless quest to eliminate risk.

The question arises, therefore, is it in the interests of patients for the profession to acquiesce every time there is a report like this, or should we be doing something else?

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Competing interests: None declared.

1 Smith R. The GMC: expediency before principle. *BMJ* 2005;330:1-2. (1 January.)
2 Dyer C. Shipman inquiry finds GMC has "fundamental flaws." *BMJ* 2005;330:10. (1 January.)

Proceed with caution

EDITOR—When a new drug is introduced, three questions must be asked and as far as possible answered before it comes into widespread use:

(1) Does it work for the condition in question?

(2) Is it safe? (In particular, are there any potential side effects that may be worse than the disease?)

(3) Is it affordable?

The drug must also be compared with other agents and therapeutic approaches, and supplementary questions asked such as who stands to profit and whether the condition is self limiting or potentially lethal.

To some principle is all—that is, even if a new drug gives only a 30% improvement and costs £10 000 per patient, it must still be given. However, that £10 000 has to come from somewhere, perhaps an unsexy condition such as leg ulcers.

Dame Janet Smith's proposals are like a new drug.[1] We are not entirely sure what condition is being treated. There is no evidence base or comparative trials. Potential side effects include an exodus from the profession of 50-something doctors who are "all reformed out" and a lack of bright teenagers entering such an over-managed career. Why not be a lawyer like Dame Janet rather than a doctor who can be suspended on an anonymous denunciation or lose her career for one mistake?

Shipman and Bristol did happen, and the performance of doctors matters. Laissez-faire is not an option. However, before we mass medicate, we need more evidence and a thorough analysis of risk and benefit.

This is a time for clear heads, not panic measures. And if we are talking about principle, then the principle of whether a government that started a bloody war which has made the world less safe should implement costly and potentially harmful vote-winning measures to control the medical profession is one that might be worth going to the barricades over.

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Summary of responses

EDITOR—The three articles discussing the forensic examination of the General Medical Council conducted by Dame Janet Smith as part of her inquiry into the issues arising from the case of general practitioner Harold Shipman sparked considerable controversy.[1–3]

Most respondents focused on the GMC rather than the report, although some took issue with the suggestion of having more medical members appointed than elected to the council. Another worry was that the conflict was playing into the government's and Department of Health's hands and becoming politicised, to the detriment of the medical profession.

One strand of the debate was whether the remit of the GMC should in fact be protecting patients (in addition to regulating doctors). Sufficiently strong self regulation would arguably protect patients, which would, in turn, protect doctors. Mostly, however, the GMC was severely criticised. Anecdotal examples of the GMC's conduct, especially towards those who expressed criticism of it, were numerous.

Several correspondents were in favour of some sort of revalidation system, and the GMC president, Graeme Catto, invited suggestions for refining the revalidation procedures. Numerous doctors pointed out that the atmosphere in the wake of revalidation was threatening and mistrustful and not in any way congenial to good medical practice or a happy professional life. One argued that the council has not acknowledged all the revisions and improvements that have happened in medical training, and the plans for revalidation are therefore bureaucratic and vague.

The GMC was perceived as having lost the trust of the public and the professionals it regulates. Must it be staffed by doctors or could it be staffed by other types of professionals—"inspectors," even?

The belief underlying most responses was that the GMC rather than the workforce it regulates is in need of reform. But expediency before principle is common because to think that no patient will ever be harmed by a doctor's incompetence is pretending. It comes down to whether the profession wants to keep the privilege of regulating itself or give it up, a way forward favoured by some. However, as one general practitioner in Leeds concludes, there will always be Shipmans—no matter what regulatory processes are in place.

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Competing interests: None declared.

1 Electronic responses. The GMC: expediency before principle. bmj.com 2005. http://bmj.bmjjournals.com/cgi/eletters/330/7481/1 (accessed 18 Jan 2005).,330:1-2. (1 January.)
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"Disaster mental health": lessons from Aberfan

See also p 262

EDITOR—One aspect of the response to the Asian tsunami disaster is "disaster mental health."[1] The tsunami prompted the Department of Health to circulate briefing papers on acute stress reactions and post-traumatic disorder throughout NHS trusts, and various experts have stated that as many as 25% of child survivors will develop "post-traumatic stress disorder" requiring professional intervention.

So too after the recent Beslan school disaster. A team of 48 psychiatrists, psychotherapists, and psychologists was assembled before the siege was over to address "profound psychological scars."[2] A team of psychologists was still manning a 24 hour hotline three months later amid expectations that many surviving children still needed trauma debriefing or would carry longterm psychiatric problems in the shape of post-traumatic stress disorder.[2]

Disaster mental health rests not on medicopsychological discoveries but on Western cultural trends. The concept of a person, particularly children, now emphasises not resilience but vulnerability, and the culture is preoccupied with trauma and emotional deficit.[3] Thus horror at what these children endured risks being transformed into assumptions about psychological damage.

These trends are comparatively recent, and it is instructive to compare Beslan with another school tragedy that shook the nation, the engulfing of 144 schoolchildren and teachers in 1966, when a coal waste tip slid into the Welsh village of Aberfan. Surviving children resumed school two weeks later so that their minds would be occupied. There was no counselling and no dire prediction of long term traumatisation and disability. Newspaper reports commended the villagers for getting back on their feet so admirably and with little need for outside help. A child psychologist noted some months later that the children seemed normal and well adjusted, and this seems to have remained true since.[4]

Literature reviews suggest that trauma debriefing should now be generally accepted as being ineffective, and even harmful. Professional intervention may unwittingly cement a preoccupation with what happened and thus retard natural recovery.

The recent consensus statement on post-emergency mental and social health endorses social assistance as having the primary role, and questions the public health value of post-traumatic stress disorder as a concept, particularly in non-Western, low-income countries.[5] The longer term outlook for these children will depend on the possibilities for the resumption of ordinary life within the family and the wider community.

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Competing interests: None declared.

1 Abbasi K. Editor's choice. Death by tsunami and poverty. *BMJ* 2005;330:0. (8 January.)
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3 Summerfield D. Cross-cultural perspectives on the medicalisation of human suffering. In: Rosen G, ed. *Posttraumatic stress disorder: issues and controversies.* Chichester: Wiley, 2004.
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Palestine: the assault on health and other war crimes

Response from Israel Medical Association

EDITOR—I write with regard to Summerfield's much debated article.[1] Many of the things that he cites, besides resonating with hatred, are presented in a complete vacuum, and we were surprised to see them published in a respectable medical journal despite the author's clear political agenda and the total lack of corroboration of any claim made.

Israel is required to defend its citizens daily from terrorist activity, an obligation that in no way contradicts the reality in which Israel, on a daily basis, provides medical care to Palestinians.

According to a report of the health coordinator of the civil administration for the West Bank, in the first half of 2004 alone, more than 200 Palestinian children received treatment in Israeli hospitals, and more than 19 000 patients were given permits to receive medical care in Israel. The civil administration also clarified 1000 delays of patients and medical personnel at roadblocks. These are only some examples, taken from the complete report, of the efforts made to ensure health services.

Not only was the care offered, 14 072 751 Israeli shekels (about $3 127 278) worth of debts of the Palestinian Authority to Israeli hospitals were offset.

The conclusion that can be drawn is that Summerfield's article is certainly a one sided view of the situation and totally disregards the context and history of the conflict.

With regard to Summerfield's obsessive and repeated attacks on the Israel Medical Association (IMA) and the World Medical Association (WMA): the IMA has been far from silent in the face of alleged health violations but rather has consistently forwarded such allegations to the army or the government to investigate and deal with. In more than one case, the allegations have proved untrue; in some cases, remedial action was taken; and in several cases, the army defended its actions.

We have met and continue to meet various Israeli, Palestinian, and international representatives to see how the situation might be improved. We have also trained medical officers in the ethical complexities of such a volatile situation, where their kindness and ethical stand might be abused. However, neither the IMA nor the WMA is

willing to take a political stand on an issue, or to give credence to the half truths and untruths expressed by Summerfield.

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Competing interests: None declared.

1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)

Israeli situation is not analogous to apartheid regime

Editor—The personal view by Summerfield generated considerable correspondence.[1 2] However, it has not addressed the concluding analogy of the Israeli situation with that which led to suspension of the Medical Association of South Africa (MASA) from the World Medical Association (WMA). Summerfield implies that since the boycott of South African medicine helped in the fall of apartheid, a boycott of Israeli medicine should be the objective.

The issues surrounding the MASA suspension are well known and have been revisited recently.[3] The complicity of the medical profession was explicit, and "apartheid medicine" itself was not "in the dock." There may be errors of judgment in Israel, but surely not in the same league?

BMJ readers may not know what apartheid medicine entailed. I am South African born and benefited from medical education within apartheid, so maybe I should be embarrassed? Leave aside maldistribution of healthcare, malnutrition, neo-Nazi pseudogenetic race classification, and racially separate wards in teaching hospitals. Take Professor Ralph Hendrickse's testimony about autopsy, where "black" students could not view a "white" body. Only one pathologist refused to cooperate.[4]

It is easy to find demographic statistics and to observe comparative care in Israeli hospitals. It is not organised on such apartheid lines. Benjamin Pogrund, an anti-apartheid journalist, today works in Israeli-Palestinian dialogue. He counters the libellous equation of Israeli medicine with apartheid medicine by personal testimony of treatment in a mixed Israeli-Palestinian environment—patients, doctors, and paramedical staff—belying the conflict outside.[5]

My personal view is from April 2002, Passover, the time of Seder bombs, and of Jenin, in a Haifa hospital, caring for elderly relatives before and after a suicide bombing. The hospital became a frontline casualty centre. There was no difference. Shared wards, communal facilities, doctors, carers, visitors—a community where sick family members took priority, as they should.

This is not to deny inequalities of health in Israel and health problems created by war. If, however, you do not differentiate this from apartheid medicine, are you undermining not only the legitimacy of Israeli medicine, but also of Israel itself?

So I can live with being one of Summerfield's "morally corrupt" people who sense antisemitism. It is more difficult to live with this corruption of the columns of the *BMJ*.

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Competing interests: DK writes in a personal capacity. He holds dual British-Israeli nationality, is a member of the Board of Deputies of British Jews; chairs the British Israel Medical Association fellowship; and has represented the Office of the Chief Rabbi on Jewish medical ethical issues. He was involved in student anti-apartheid protest and was chairman of the Association of Medical Students of South Africa in the 1960s.

1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)
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5 Pogrund B. *Jerusalem. Something to write about.* Johannesburg: Jacana, 2004:251.

Full engagement in health

Shared decision making requires education

Editor—Coulter and Rozansky's point that full engagement in health needs to begin in primary care is a timely reminder that the move towards patient partnership and shared decision making (the focus of a *BMJ* issue in 1997) is stalling.[1]

The results of the Commonwealth Fund's study is not surprising, and I postulate that there are at least two fundamental causes of the poor British results.

One of the striking findings of my research for a PhD on shared decision making and medical education is that medical students are rarely encouraged to develop management plans. If and when they do they are unlikely ever to discuss them with patients, let alone involve patients in choosing options. However pre-registration house officers, particularly those in general practice, are active in patient management and develop skills to discuss plans with patients. But patients are often not given choices: the plans are decided by the doctors. Those junior doctors who begin to develop strategies to share decisions are unlikely to be given feedback on their fledgling skills. Undergraduate and postgraduate medical educators need to think about this area of medical professionalism.

The second cause is related to the general practice contracts, particularly the new one of 2004. A colleague who has practised as a general practitioner for many years in Australia is currently on sabbatical in the United Kingdom. He reports that general practitioners are concentrating on meeting the targets of the new contract with a loss of communication and patient involvement in consultations. Moreover, the move from standard Australian 15 minute consultations to the United Kingdom's 10 affects the doctor's ability and motivation to discuss options with patients.

Shared decision making needs to begin in primary care, but learning and working environments must be changed to ensure a good outcome.

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Competing interests: None declared.

1 Coulter A, Rozansky D. Full engagement in health. *BMJ* 2004;329:1197-8. (20 November.)

Government programmes aim to improve engagement

Editor—In their editorial on full engagement in health Coulter and Rozansky refer to the benefits of chronic disease self management and the need to build health literacy among patients.[1]

In England the expert patient programme is one route to realise the benefits of such management and the skilled for health programme a route to build health literacy (S Gupta, seventh European health forum, Gastein, October 2004).[2]

Coulter and Rozansky also refer to the role of patient empowerment in public health. However, self efficacy, which underlies chronic disease self management, is also associated with a healthy lifestyle. Thus the principles underlying the expert patient programme could be extended to the whole population. Promoting such self regulation of health related behaviour could have enormous benefits in improving health outcomes and containing healthcare costs.[3] This is also entirely consistent with the philosophy underlying the new white paper *Choosing Health*, which aims to support individuals to make informed choices about their health.[4]

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Competing interests: AG is the former chair of the Expert Patient Programme Implementation Group.

1 Coulter A, Rozansky D. Full engagement in health. *BMJ* 2004;329:1197-8. (20 November.)
2 Donaldson L. Expert patients usher in a new era of opportunity for the NHS. *BMJ* 2003;326:1279-80.
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Sentinel systems are needed for long term adverse drug reactions

Editor—In the wake of the withdrawal of rofecoxib, the limitation of the current system of pharmacovigilance is once again under discussion. With the system's focus on spontaneous reports, unexpected and rare reactions occurring shortly after exposure are usually detected with reasonable sensitivity. However, adverse effects are not readily identified if they occur after long time exposure or manifest themselves as an increase of a common disease. The cardiovascular events caused by rofecoxib belong to the latter group.

Although attractive in theory, the proposal of Dieppe et al to require independent, large scale, randomised trials before definitive drug licensing, is associated with some problems.[1] As Oakley points out,[2] the sample sizes needed to investigate rare adverse reactions in traditional randomised controlled trials would increase costs for clinical development and ultimately raise drug prices. Furthermore, over time, treatment switches and discontinuations often transform large and simple randomised trials into observational cohort studies. Instead, Oakley wants to promote the use of cost effective case-control studies. In selected cases, when a clear hypothesis exists about the nature of the reaction and some idea of the suspected drugs, case-control studies can provide important information. However, as a strategy for continuous post-marketing surveillance of unexpected effects, they are not so suitable.

In recent years large databases originating from routine healthcare procedures have become widely available. Although collected for other purposes, the information in these data sources could have an important role as a cost effective sentinel system for long term adverse drug reactions. However, the abundance of information in healthcare databases requires techniques for research to move beyond traditional epidemiological study designs, inherited from an era when data collection was expensive and yielded only a few facts for each study subject.[3]

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Competing interests: As a former employee of AstraZeneca, TC has dividends that currently are in the process of being divested.

1 Dieppe PA, Ebrahim S, Martin RM, Jüni P. Lessons from the withdrawal of rofecoxib. *BMJ* 2004;329: 867-8. (16 October.)
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Why doctors don't read research papers

Editors' behaviour might have something to do with it

Editor—Having written or co-written several original research papers and review articles during my professional life, I believe that one of the reasons that we don't read research papers is because, despite protestations to the contrary, editors regularly seem to indulge in behaviour that goes against all the principles of good writing, including insisting on the use of po-faced titles which do not even attract the reader's attention in the first place.[1]

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1 Barraclough K. Why doctors don't read research papers. *BMJ* 2004;329:1411. (11 December.)

Scientific papers are not written to disseminate information

Editor—I sympathise with Barraclough.[1] The reader deterring style in which most scientific papers are written has evolved because they are written not to be read but to be published. Authors are eager to get their names in print not because they are bursting to tell us something but for more solemn reasons. Another paper means another line on a curriculum vitae, another step towards a job or a research grant.

In 1976 in the *Lancet* we missed one of the great opportunities of 20th century medicine when Dr J B Healy, like another Irishman 250 years before him, submitted a modest proposal:

"It seems to me that we should for an experimental period of a year, declare a moratorium on the appending of authors' names and of the names of hospitals to articles in medical journals. If the dissemination of information is the reason why papers are submitted for publication, there will be no falling off in the numbers offered … But if far less material is offered to the journals, we shall have unmasked ourselves."[2]

No editor has yet been brave enough to conduct that experiment. Not even Richard Smith, who when editor of the *BMJ* said that only 5% of published papers reached minimum standards of scientific soundness and clinical relevance, and in most journals the figure was less than 1%.[3]

The reluctance to take up Dr Healy's suggestion confirms the observation of the editor of *Nature* that scientific papers serve the needs of their authors above those of their readers.[4] Why else would a journal devote five pages to a paper that reached this conclusion? "In this pilot study, the null hypothesis that both treatments will show equal results cannot be confirmed or rejected because of the small number of participants."[5]

We need to exorcise the myth that, to write readably about science, authors have to write superficially or grossly simplify their subject. The real challenge is to present complexity in an understandable way. Anyone who has tried to do it knows that it is hard work. The writers of too many scientific papers are not prepared to make the effort.

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Competing interests: None declared.

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Author's reply

Editor—The responses to my article are interesting.[1] I had not intended to imply that doctors do not read medical papers because they are ignorant or lazy. I have come across a few of both in my career, but in my experience they are a minority. I was trying to make two points within 400 words and, I think, made neither very succinctly.

Ide elaborates on the first point. I believe that the style required by scientific editors is slightly dishonest. Most researchers are not disinterested observers. They have a point of view that is valid and interesting but personal. It is disingenous for editors to require the impersonal style. It would be more honest to substitute "we did this" for "this was done" and to ask authors to be explicit about their own beliefs on the subject.

The second is a point about statistical analysis. I am not mathematically illiterate. I believe that most statistical analysis could be explained comparatively simply in terms that the averagely numerically literate person could understand, while at the same time identifying those statistical arguments that are not obvious.

How many authors of papers, or editors, could explain when an odds ratio approximates to a relative risk in a case-control study, and why? The assumption that readers should understand these matters, or should not prescribe prescription only medicines, is simplistic and slightly patronising. I have studied a lot of mathematics. The area I continue to find most difficult to understand intuitively is statistics. In many papers, the line of argument runs reasonably succinctly until the statistical analysis, at which point it runs into the thickets of obscurity. It is not reasonable to expect practitioners of medicine, which is an extremely complex and busy discipline within the NHS, to have the same grasp of the nuances of statistical argument as a fulltime researcher or a mathematician.

Most doctors want to practise competently. To do this they read editorials or commentaries and not original papers. They do this because the style required of original papers is disingenuous and opaque. I think this could be changed.

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Competing interests: KB wrote the short piece.

1 Electronic responses. Why doctors don't read research papers. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7479/1411 (accessed 18 Jan 2005).